

# **RENEWAL**

## **PROFESSIONAL EMPLOYER ORGANIZATION APPLICATION FOR LICENSURE MONTANA**



**The application fee is:**

\_\_\_ **\$750.00 Unrestricted license**  
\_\_\_ **\$500.00 Restricted license**

**Fees Payable To:** Department of Labor and Industry  
Employment Relations Division

**Mailing Address:** PO Box 8011, Helena MT 59604-8011

**Street Address:** 1805 Prospect Avenue, Helena MT 59601

**Contact Person:** Brett Wall, PEO Compliance Specialist  
**Phone :** (406) 444-0776  
**Email :** [brwall@mt.gov](mailto:brwall@mt.gov)  
**Web Address :** <http://erd.dli.mt.gov/wcregs/profemporgs.asp>

**Important Information  
(Must be completed)**

FEIN(s): \_\_\_\_\_ Applicant Entity(s) to include Montana a/b/n or d/b/a:

\_\_\_\_\_

Street and Mailing Address: \_\_\_\_\_

Branch Offices \_\_\_\_\_ Yes \_\_\_\_\_ No (If yes, attach listing of all branch locations, street addresses and phone numbers)

Contact Person(s): \_\_\_\_\_

Business Phone # \_\_\_\_\_ Email(s): \_\_\_\_\_

State Unemployment Tax Account(s) (SUTA): \_\_\_\_\_

Workers' Compensation Policy Number(s): \_\_\_\_\_

Effective Date(s): \_\_\_\_\_

Name of Insurer: \_\_\_\_\_

Insurer Address: \_\_\_\_\_

Insurer Contact Phone/Email: \_\_\_\_\_

Montana In-State Claims Examiner: \_\_\_\_\_

**BENEFITS PROGRAMS:** A professional employer organization or group shall disclose to the department, to each client, and to its employees information on any health or life fringe benefit program provided for its employees.

Are benefits provided \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please complete the following information or submit as an attachment:

Type of benefits: \_\_\_\_\_

Identity of each Insurer providing coverage: \_\_\_\_\_

Amt of benefits for each type of coverage: \_\_\_\_\_

Policy limits on each insurance policy: \_\_\_\_\_

Whether coverage is fully insured, partially insured or fully self-funded: \_\_\_\_\_

## CHECKLIST A:

The following supporting documents must be submitted with your application for compliance with Title 39, Chapter 8 Montana Code Annotated (MCA). Please read the instructions carefully to ensure proper completion of the application. The non-refundable application fee is \$750 for a resident or nonresident unrestricted license, or \$500 for a restricted license.

\_\_\_\_ Financial Statements-Pursuant to 39-8-202 (6)(a) (MCA), Except for an applicant who is granted a restricted license under subsection (9), an applicant shall maintain a tangible accounting net worth of not less than \$50,000, evidenced by: (i) providing financial statements that have been independently **audited** by a certified public accountant in accordance with generally accepted accounting principles; **or** (ii) providing independently **compiled** financial statements **and a \$100,000 security deposit** in a form that is acceptable to the department. 39-8-202 (7) MCA, The applicant shall maintain a positive working capital, as evidenced by financial statements (reference

\_\_\_\_ Attestation of Financial Statement (reference 39-8-202 (6)(c)(ii) MCA)

\_\_\_\_ Proof of workers' compensation for each client company. If no clients, provide MT endorsed master policy. (reference 39-8-207 (4)(c) MCA) Note: If your insurer provides policies to this office or you previously submitted policies, please don't duplicate!

\_\_\_\_ List of Montana Client Companies – (reference 39-8-207 (2)(e) (MCA) currently under contract with the applicant, including the name of the business, their Federal Employer ID number, business address, primary business operation and the beginning date of the contract.

\_\_\_\_ Declaration of Accuracy form (reference 39-8-202 (5)(a)(iii) MCA)

\_\_\_\_ Applicant/Controlling Person Questionnaire (reference 39-8-202 (5)(a)(iii) MCA)

## CHECKLIST B:

### THE FOLLOWING NEED TO BE SUBMITTED IF CHANGES HAVE OCCURRED OR OCCUR DURING THE LICENSE YEAR.

\_\_\_\_ List of Branch Offices and Business Operational History: reference 39-202(5)(a)(i) MCA

Pursuant to 39-8-207(2)(d) MCA **Requirements of Licensee** The professional employer organization or group shall: notify the department in writing within 20 days of a change of business address or a change in partners, directors, officers, members, or controlling persons designated in the license. **The following forms should be used for these changes:**

\_\_\_\_ **APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION**

\_\_\_\_ **PEO OWNERSHIP INFORMATION**

\_\_\_\_ **PEO GROUP GUARANTEE FORM**

\_\_\_\_ **APPLICANT/CONTROLLING PERSON INFORMATION SHEET**

\_\_\_\_ **CONTROLLING PERSON AUTHORIZATION FOR RELEASE OF INFORMATION**

\_\_\_\_ **CHARACTER REFERENCE AFFIDAVIT (needs to be notarized)**

Pursuant to 39-8-207(2)(e) MCA **Requirements of Licensee** The professional employer organization or group shall: notify the department in writing within 20 days after a client either commences or terminates a professional employer arrangement or an employee leasing arrangement with that professional employer organization or group. **The following form should be used and can be emailed, once completed:**

\_\_\_\_ **PROFESSIONAL EMPLOYER ARRANGEMENT CLIENT INITIATION OR TERM FORM**

Pursuant to 39-8-207(1) (2) MCA **Requirements of Licensee** A professional employer organization or group shall, by written contract with the client, establish the responsibilities and duties of each party.

\_\_\_\_ Client contract agreements and or Employee Disclosure

## PROFESSIONAL EMPLOYER ARRANGEMENT CLIENT INITIATION OR TERMINATION FORM

39-8-207 (2)(e) Montana Code Annotated, states the professional employer organization or group shall: notify the department in writing within 20 days after a client either commences or terminates a professional employer arrangement or an employee leasing arrangement with that professional employer organization or group.

Please furnish a copy of this completed form:

Email: [brwall@mt.gov](mailto:brwall@mt.gov)

Fax: 406-444-7710

Mail: State of Montana

Department of Labor & Industry

Employment Relations Division

Attn: Brett Wall

PO Box 8011, Helena MT 59604-8011

1805 Prospect Avenue, Helena MT 59601

Phone: 406-444-0776

DLI/ERD use only

Excel: \_\_\_\_\_

Policy: \_\_\_\_\_

NCCI: \_\_\_\_\_

POC: \_\_\_\_\_ WCAP: \_\_\_\_\_

UEF Letter: \_\_\_\_\_

Notes: \_\_\_\_\_

### Employee Leasing Company Information:

Name of Company: \_\_\_\_\_

Address of Company: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone # \_\_\_\_\_

Federal Tax ID #: \_\_\_\_\_

=====

### Client Company Information:

Name of Client Company: \_\_\_\_\_

Address of Client Company: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone # \_\_\_\_\_

Federal Tax ID #: \_\_\_\_\_

Month, Day and Year leasing arrangement **initiated in Montana**: \_\_\_\_\_

Month, Day and Year leasing arrangement **terminated**: \_\_\_\_\_

Reason for **termination**: \_\_\_\_\_

WC class codes used for this client: \_\_\_\_\_

WC policy number: \_\_\_\_\_ Policy effective date: \_\_\_\_\_

=====

Completed by: \_\_\_\_\_

Date form completed: \_\_\_\_\_

**Note: If applicable, please provide the business location and/or employee status within Montana.**

## ATTESTATION OF FINANCIAL STATEMENT

We, the undersigned, in conformance with section 39-8-202, MCA, do hereby attest to the accuracy and completeness of the financial statements **submitted herein** and **attached hereto** by \_\_\_\_\_ (applicant) as part of the application process for licensure as a Professional Employer Organization.

attest: \_\_\_\_\_

_____	_____
Date	Signature and printed name of applicant <b>president</b>

attest: \_\_\_\_\_

_____	_____
Date	Signature and printed name of <b>chief financial officer</b>

attest: \_\_\_\_\_

_____	_____
Date	Signature and printed name of a <b>controlling person</b>

## DECLARATION OF ACCURACY

I, \_\_\_\_\_, declare that to the best of my knowledge the applicant is qualified in all respects for the license for which applied in this application; that all of the questions in this application have been answered truthfully; that all supporting documents, submitted with this application are true, correct, complete and valid; and that there have been no material omissions of fact which would have bearing upon the State of Montana's decision to grant the requested license.

I understand and agree that furnishing false information or failing to disclose material information regarding the applicant's background and qualifications is grounds for refusing to issue a license and/or the revocation of a license already issued. I also understand that making false statements under penalty of perjury may subject me to criminal liability.

I declare that: (check one)

\_\_\_\_\_ I am the named applicant for licensure as a Professional Employer Organization

\_\_\_\_\_ I am the \_\_\_\_\_ (title) of \_\_\_\_\_  
and I have been duly authorized to execute this Declaration on behalf of the applicant.

I declare under penalty of perjury of the laws of the State of Montana that the above statements and the statements made in this Application for Professional Employer Organization License are true and correct. I declare that this declaration was executed on

\_\_\_\_\_, 20\_\_\_\_ at

\_\_\_\_\_ (city), \_\_\_\_\_ (state).

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**Printed name, signature and title of a control person**

**APPLICANT/CONTROLLING PERSON  
INFORMATION SHEET**

A separate form must be completed for each applicant or each controlling person, if applicable.

**1. NAME OF (APPLICANT/CONTROLLING PERSON)**

\_\_\_\_\_  
(Typed or Printed, Full Legal Name – First, Middle, Last)

**2. SOCIAL SECURITY NUMBER** \_\_\_\_\_

**3. MAILING ADDRESS** \_\_\_\_\_

(Number & Street or PO Box, City, County, State, Zip)

**4. HOME ADDRESS** \_\_\_\_\_

(Number & Street or PO Box, City, County, State, Zip)

**5. TELEPHONE NUMBER** \_\_\_\_\_

(Area Code/Number)

**6. DATE OF BIRTH** \_\_\_\_\_

**7. TITLE OF CONTROLLING PERSON**    ☐ Owner   ☐ Manager   ☐ Other

**8. LIST BELOW** employment history for the last four (4) years, identify management and supervisory positions. (Attach additional sheets if necessary and reference item number.)

EMPLOYER & ADDRESS	DATE FROM/TO	TELEPHONE NUMBER	BRIEF DESCRIPTION OF RESPONSIBILITY
A.			
B.			
C.			
D.			

## APPLICANT/CONTROLLING PERSON QUESTIONNAIRE

The applicant/controlling person should complete this form.

If the answer to any of the following questions is “YES” attach a full explanation detailing the circumstances or condition which cause the “YES” answer. Any bankruptcy within the last 10 years must attach Schedules A & B and the court order discharging the bankruptcy.

	YES	NO
1. Does the applicant, controlling person, officer, director, shareholder, or partner now hold or have they ever held an employee leasing company, or authority to practice as an employee leasing company in the State of Montana or any other state?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the applicant or any officer, controlling person, director, shareholder, member, partner, owner or managing employee:		
a. been convicted of, pled guilty to, or entered a plea of no contest to any criminal violation?	<input type="checkbox"/>	<input type="checkbox"/>
b. ever filed for, or been subjected to an involuntary petition for, or been adjudged bankrupt, or sought protection under the bankruptcy laws?	<input type="checkbox"/>	<input type="checkbox"/>
c. had a judgment entered against them in any court?	<input type="checkbox"/>	<input type="checkbox"/>
d. applied for and been denied a bond?	<input type="checkbox"/>	<input type="checkbox"/>
e. had a bonding company or surety make a financial settlement in their behalf?	<input type="checkbox"/>	<input type="checkbox"/>
f. had a bonding company or surety revoke a bond or surety agreement executed in their behalf?	<input type="checkbox"/>	<input type="checkbox"/>
g. had a license or authority to practice denied, revoked, suspended, placed on probation or been subject to disciplinary action or restriction?	<input type="checkbox"/>	<input type="checkbox"/>



## APPLICANT/CONTROLLING PERSON QUESTIONNAIRE (page two)

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 3. Are there now any outstanding unpaid past due bills; claims for salaries, wages, benefits or services; judgments, assessments or liens resulting from acts or omissions of this applicant, controlling person, officer, director, shareholder, member, partner, owner, or managing employee, for which these persons may be responsible? | <input type="checkbox"/> | <input type="checkbox"/> |

I, \_\_\_\_\_, do hereby certify that all of the questions in this applicant/controlling person questionnaire have been answered truthfully; that all supporting documents, submitted with this questionnaire are true, correct, complete and valid; and that there have been no material omissions of fact which would have bearing upon the State's decision to grant the requested license to the Professional Employer Organization applicant.

I understand and agree that furnishing false information or failing to disclose material information regarding the applicant's background and qualifications is grounds for refusing to issue a license and/or the revocation of a license already issued. I also understand that making false statements under penalty of perjury may subject me to criminal liability.

I declare under penalty of perjury of the laws of the State of Montana that the statements made in this Applicant/Controlling Person Questionnaire are true and correct. I declare that this declaration was executed on \_\_\_\_\_, 20\_\_\_\_ at \_\_\_\_\_ (city), \_\_\_\_\_ (state).

\_\_\_\_\_  
Printed name and Signature

## CONTROLLING PERSON AUTHORIZATION FOR RELEASE OF INFORMATION

(A separate form must be completed for each controlling person)

I, \_\_\_\_\_, hereby authorize all persons, institutions, organizations, schools, governmental agencies (including criminal justice agencies and tax authorities), employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in the Applicant/Controlling Person questionnaire, to release to the State of Montana, Department of Labor and Industry, Employment Relations Division ("the Division"), and its employees, agents and attorneys, any files, records or information of any type reasonably required for the Division to properly evaluate my eminence in regard to the application for licensure as a Professional Employer Organization by the State of Montana.

**A copy of this authorization may be used with the same effect as the original.**

\_\_\_\_\_  
\_\_\_\_\_

Date	Printed name and Signature
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Date of Birth \_\_\_\_\_

Social Security No. \_\_\_\_\_

**STATE OF MONTANA, DEPARTMENT OF LABOR AND INDUSTRY  
PROFESSIONAL EMPLOYER ORGANIZATION  
CHARACTER REFERENCE AFFIDAVIT**

STATE OF \_\_\_\_\_)

: SS

COUNTY OF \_\_\_\_\_)

\_\_\_\_\_, being first duly sworn says:

1. That I have known \_\_\_\_\_ (printed name of applicant/controlling person) for at least three years and know that he/she is of good moral character and has a reputation for honesty and fair dealing.
2. That I am not related by blood or marriage to the person named in paragraph 1.
3. That I am not a controlling person in the Professional Employer Organization for which this character reference relates.

By: \_\_\_\_\_

(signature of affiant)

**SUBSCRIBED AND SWORN** to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

(Seal)

\_\_\_\_\_  
**Notary Public for the**

**State of** \_\_\_\_\_

**Residing at** \_\_\_\_\_

**My commission expires** \_\_\_\_\_

# PEO OWNERSHIP INFORMATION

Provide information for all owners, partners, corporate officers, shareholders with greater than 5% interest, and limited liability company individuals who have a 5% or greater interest in the company.

NAME	ADDRESS (P.O. BOX NOT ACCEPTABLE)	SOCIAL SECURITY NUMBER	AGE	TITLE	% OF VOTING INTEREST

Use this space to provide “Business Operational History” (reference 39-8-202 (5)(a) MCA)

List by jurisdiction of each name under which the applicant has operated in the preceding 5 years, including any alternative names, names of predecessors, and names of related business entities with common majority ownership.

## APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize all persons, institutions, organizations, schools, governmental agencies (including criminal justice agencies and tax authorities), employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this license application, to release to the State of Montana, Department of Labor and Industry, Employment Relations Division ("the Division"), and its employees, agents and attorneys, any files, records or information of any type reasonably required for the Division to properly evaluate the applicant's qualifications for licensure as a Professional Employer Organization by the State of Montana.

A copy of this authorization may be used with the same effect as the original.

\_\_\_\_\_ **By:** \_\_\_\_\_

\_\_\_\_\_

Date	Printed Name, Signature and Title
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Name of Applicant: \_\_\_\_\_

Applicant's FEIN or Social Security Number: \_\_\_\_\_

# PROFESSIONAL EMPLOYER ORGANIZATION GROUP GUARANTEE FORM

Pursuant to the provisions of the Montana Professional Employer Organizations and Groups Licensing Act, the undersigned, hereby: 1) unconditionally guarantee and promise to pay any and all financial obligations of each entity of the group with respect to wages, payroll-related taxes, insurance premiums, and employee benefits; 2) authorize any entity of the group to act on behalf of the group; and 3) guarantee that each PEO within the group is majority-owned by the same person.

Guaranteeing Entity to include FEIN:

\_\_\_\_\_

\_\_\_\_\_  
Signature of certifying Controlling Person

\_\_\_\_\_  
Printed Name of certifying Controlling Person

State of \_\_\_\_\_

County of \_\_\_\_\_

Before me, personally appeared \_\_\_\_\_ (controlling person of \_\_\_\_\_), whose identity is known to me by \_\_\_\_\_ (type of identification) and who, under oath, acknowledge their signature appears above. Sworn and subscribed before me this day of \_\_\_\_\_, 20\_\_\_\_.

(Seal)

\_\_\_\_\_  
Notary Public  
My Commission Expires:

- (1) First entity name and FEIN:\_\_\_\_\_
- (2) Second entity name and FEIN:\_\_\_\_\_
- (3) Third entity name and FEIN:\_\_\_\_\_
- (4) Fourth entity name and FEIN:\_\_\_\_\_
- (5) Fifth entity name and FEIN:\_\_\_\_\_